

The Family Health Support Core (NASF) and Health Practices: Are There Many Challenges to Be Overcome?

REVIEW

Djavan Gomes Leite¹, Maurício Caxias de Souza²,
Danielle Aurília Ferreira Macêdo Maximino², Eva Pôrto Bezerra²,
Josélio Soares de Oliveira Filho², Nereide de Andrade Virgínio²,
Cláudia Germana Virgínio de Souto², Déa Sílvia Moura da Cruz²,
Amanda Benício da Silva², Camila Navarro Rocha Saraiva³,
Emmanuella Costa de Azevedo Mello⁴,
Andréa Márcia Cunha Lima³, Lucas Cunha Pimenta Barbosa⁵,
Daniela Karina Antão Marques², Vanessa Serrano Bezerra²,
Gerson da Silva Ribeiro³

- 1 Student of the Physical Therapy Course. João Pessoa (PB), Brazil.
- 2 College the Nursing and Medical Nova Esperança (FACENE/FAMENE). João Pessoa (PB), Brazil.
- 3 University of Paraíba (UFPB). João Pessoa (PB), Brazil.
- 4 Faculty of Nursing São Vicente de Paula (FESVIP). João Pessoa (PB), Brazil.
- 5 Maternity Frei Damião. João Pessoa (PB), Brazil.

Contact information:

Danielle Aurília Ferreira Macêdo
Maximino.

 dannyaurilia@hotmail.com

Abstract

Goal: Describe and characterize NASF health practices.

Method: It is a review of current literature carried out by consulting the database Lilacs and Virtual Library of SciELO in the period from December 2016 to January 2017.

Conclusion: It is concluded that, although the NASF is recognized as a support to the Family Health Strategy (FHS), still does not act in an articulated way, being fundamental that changes take place in the organization of the services and in the conduct of the health professionals who contemplate it.

Introduction

It is understood that the Family Health Support Center (NASF) emerged as a proposal both to provide assistance to the population demands not reached by the teams that make up the Family Health Strategy (ESF) and also to support these teams in the implementation of the network Services and extend its coverage, in order to improve the

Keywords

Primary Health Care; Family Health; Public Health Policies; Nursing.

quality of assistance to the population at the level of Primary Care (AB), which requires more effective actions.

For these researchers, in contrast to conventional care models, which teach for curative, specialized, fragmented and individual assistance, NASF's proposal is to overcome this logic towards co-responsibility and integrated care management by Means of shared care and therapeutic projects that involve the users and are able to consider the uniqueness of the subjects assisted during the development process.

The implementation of the NASF represents the increasing search for the integrality of the attention and interdisciplinarity in the health actions, according to the perspective of consolidation of the ESF. In this sense, the NASF is ambitious and may even seem utopian, especially when evaluating the training of health professionals, who are still largely distant from the perspectives with which the NASF was created [1].

Reflecting on the NASF's trajectory from its inception to the present time, it is perceived that the expectations with the creation of this nucleus were based on the expansion of the health services offer in the FHT, both in quantitative and qualitative aspects. However, this reality has not yet materialized due to the lack of training and qualification of the health professionals who compose it, as well as those who are part of the ESF teams, since several of these professionals also have a fragmented view regarding care, implying directly in the quality of care provided, whether individual or collective.

The NASF is formed by a support team and the main objective of its actions is to enable a better quality of assistance and not only to "supply the demand". It presents, among its challenges, the need to change the organizational culture in the Unified Health System (SUS), which has historically prioritized the number of procedures to the detriment of its quality; the referencing in detriment of the resolvability in Primary Care (AB) and the impact as-

essment and health indicators with a simply quantitative approach to their fulfillment [2].

Considering the health care offered by the SUS and the perspective on the NASF, changes in this system are necessary, whether they are within the management or the domain of the execution of qualified actions of health professionals, since the predominant culture in health practices is still considered a challenge that the NASF needs to overcome in order to validate, in fact, its guidelines.

This study aimed to reflect on NASF perspectives and challenges regarding health practices, based on existing literature on NASF implementation, challenges and achievements.

Method

This is a descriptive, literature review, initially performed through the Virtual Health Library (VHL), which houses globally recognized databases. The search for the studies occurred in the period from December 2016 to January 2017, from the following Health Sciences Descriptors (DECs): "Primary Health Care", "Family Health" and "Public Health Policies". The result led to the research in the Virtual Library of the Scientific Electronic Library Online (SciELO) and the Latin American and Caribbean Literature Database (LILACS) and Nursing Database (BDENF). The survey was extended to the archives of the Ministry of Health of Brazil.

The criteria used to include the material accessed were: online availability of the full text, publication period between 2007 and 2017, and Portuguese and English. We found 48 articles related to the theme, of which 10 (ten) were selected because they were pertinent to the object of the study and fit the established inclusion criteria.

The selected articles were analyzed based on the proposed objective of the present study and the scientific and social relevance. Then the files were read by all the authors, at different times.

Data Collection Instrument

Authors
Year
Database
Goal
Method
Conclusion

Results and Discussion

The ESF, as a public strategy that articulates primary health care for the individual, family and community health, should follow paths and thus be modified taking into account the social determinants of health in a given locality. Concomitantly, NASF has a legal and instrumental contribution that can be approached with this reality, provided that it is configured in effective matrix support for FHS [3].

NASF. History and characterization

The Ministry of Health (MS) created NASF 1 and 2 through GM/MS No. 154, published on March 4, 2008 with the objective of broadening the scope of the actions of Primary Care (AB), as well as maximizing its Resolubility, supporting the inclusion of the FHT in the services network and in the processes of territorialization and regionalization from the Basic Attention [4].

In 2008 the NASF was divided into three modalities

NASF 1, NASF 2 and NASF 3. NASF 1 was developed to serve municipalities with a population contingent of more than 20,000 inhabitants. As a result, about 80% of Brazilian municipalities have a population of less than 20,000 inhabitants, and several of them require more health monitoring than the more populous municipalities, the Federal Government, aiming to broaden the coverage of the action, created the NASF 2, intended to accommodate municipalities with a population density of up to 10 inhabitants per km² [5]

Under the SUS, NASF 3 was created based on GM/MS Ordinance No. 2,843, dated September 20, 2010, and had as its priorities the integral health care and also mental health - mainly assisting subjects who do Use of crack, alcohol and other drugs, in Primary Care (AB) - in municipalities with a population of less than 20,000 inhabitants [6].

With the prospect of filling gaps that had not initially been foreseen in the field of Basic Attention and should be prioritized - mainly because they are population groups -, the insertion of mental health and rehabilitation, as part of the integration into the service network, became necessary, as it happened from the implementation and implementation of NASF 3. Thus, interdisciplinarity, intersectorality, territory, Continuing education in health, health promotion and humanization [1].

The Ordinances GM/MS No. 154/2008 and 2,843/2010 were revoked by Administrative Rule GM/MS No. 2,488, of October 2, 2011. In this context, changes occurred in the NASF, which began to be organized in only two modalities: NASF 1 and NASF 2 [7]. It should be noted that the provisions of previous directives that do not conflict with the current ordinance remain in force.

NASF 3 has been deleted since the publication of GM/MS Ordinance No. 2,488/2011 and automatically became NASF 2. Municipalities with NASF 3 projects previously sent to the MS should now send to the Bipartite Interagency Committee a document that informs the changes that have occurred. The financing of the inter-municipal NASFs already authorized at an earlier date is guaranteed, but the possibility of implementing new inter-municipal NASFs [7].

The composition of the NASF is based on the reference team proposal, that is, it is based on those who have the responsibility for conducting an individual, family or community case, aiming to broaden the possibilities of building the link between professionals and users. This type of arrangement seeks to change the dominant pattern of responsibilities

in organizations and build accountability of people by people.

According to changes presented in Administrative Rule GM/MS No. 2,843, published on September 20, 2010, NASF 1 carries out its activities linked to at least eight and a maximum of fifteen Family Health Teams or basic health care teams for populations Specific. The exception is for municipalities with less than 100,000 inhabitants in the states of Legal Amazon and Pantanal Sul-mato-grossense, where each NASF 1 can carry out its activities linked to a minimum of five and a maximum of nine teams. As for NASF 2, it must carry out its activities linked to at least three and at most seven Family Health Teams [7].

NASF 1 and 2 should have a team of higher-level professionals to be defined by the municipal managers based on epidemiological data, local needs and health teams that will support. Thus, the professionals that comprise them are: Physician Acupuncturist, Social Worker, Physiotherapist, Physiotherapist, Speech-Language Pathologist, Pharmacist, Gynecologist, Obstetrician, Homeopathic Physician, Nutritionist, Pediatrician, Psychologist, Occupational Therapist, Physician Psychiatrist, Internist Doctor, Work Doctor, Veterinarian, professional with training in art and education and Health Professional Sanitarist [7]. It is important to note that there is no difference between NASF regarding the composition of professionals.

The NASF works with the reference team, which is also defined by coordination, management, common. It is the duty of such a team to deconstruct, in health organizations, the model of fragmented 'production lines', in which managerial power is tied to fragmented disciplinary knowledge and managers are divided by corporations, producing arrangements that devalue or rival the categories involved In the process of health care.

The organization and development of the NASF's work process depends on some strategies already tested in Brazil, such as the Matrix Support, Expanded Clinic, Singular Therapeutic Project (PTS) and the Health in the Territory Project (PST) [8].

In defining the fundamental models of operation of the NASF, it is necessary to consider the Matrix Support, which presents the dimensions of the assistance and technical-pedagogical support. The assistance dimension is one that will produce direct clinical action with the users. The technical-pedagogical dimension will produce educational support action with and for the team. These two dimensions can and should be associated at different times, since it is not possible for any health worker to avoid dealing with the affections in therapeutic relationships [9]

The proposal for an Expanded Clinic is aimed at all clinic professionals, in a clipping - a highlight of symptoms and information - of their professional competence. The PTS, however, constitutes a set of articulated therapeutic behaviors for each individual or collective subject, the result of the collective discussion of an interdisciplinary team and, if necessary, with matrix support [10].

It also uses as a working tool of the Family Health Teams and the NASF the proposal of the PST in order to develop effective actions in the production of health in a territory, articulating the health services with other services and social policies, in order to invest in the quality of life and in the autonomy of the communities [10].

New scenarios and projects that expand the NASF's action

According to Federal Decree No. 7,508/2011, which regulates Law No. 8,080/1990 and provides for the organization of the public health system, health planning, health care and inter-relationships, it is possible to think about the restructuring of the NASF through the implantation of the "Health Regions ". A Health Region is a continuous geographical area consisting of a grouping of bordering municipalities, delimited from cultural, economic and social identities, and shared transport infrastructure and communication networks, with the purpose of in-

tegrating the organization, planning and execution Actions and services [11].

Here is a difficulty often faced by municipalities that have less than 20,000 inhabitants and who, until then, could not host NASF 1. Each region must offer primary, emergency and emergency services, psychosocial care, specialized outpatient and hospital care, and, finally, health surveillance [12].

NASF, composed of professionals from different areas of knowledge, must act in an integrated manner and support the professionals of the Family Health Teams and the Primary Care Teams for specific populations. In this way, some of the existing AB teams, such as the Street Offices, as well as the Family Health Teams of the riverside and mobile fluvial units, with specific design and financing, were better incorporated into the realities in which they operate. With this, the action of NASF professionals will collaborate on the success of the Health Academy program, created by GM/MS Ordinance No. 719/2011 [12].

In Street Offices, teams should carry out their activities in a mobile way, developing actions in the street, in specific facilities, in the mobile unit and in the Basic Health Units of the territory where they are working, always articulated and developing actions in partnership with the other Primary Care Teams of the territory - the UBS and NASF -, with the Psychosocial Care Centers, the Emergency Network and the services and institutions that are part of the Unified Social Assistance System, among others Public institutions and civil society [7].

The Family Health Teams for the care of the *Ribeirinha* Population can perform most of their functions in basic health units located in the communities belonging to the attached area. On the other hand, the Fluvial Family Health Teams, perform their functions in Basic Fluvial Health Units, in order to provide assistance to that population [11]. In this sense, these teams can expand their interventions with the support of the NASF when they are operating in the municipality.

NASF can use the Health Academies as a space with the objective of expanding the collective intervention capacity of the basic health care teams for health promotion actions, in order to strengthen the *protagonism* of social groups in conditions of vulnerability with a view to overcoming their condition [7].

NASF in its applicability in the health strategy of the municipal family

The proposal to create the NASF is an important strategy to promote the strengthening of the FHT and, in particular, to develop and improve a new model of health care, aimed at multiprofessional teamwork. Guidelines, such as integrality, quality of care, equity and social participation need to be affirmed in collective actions centered on human development and health promotion, and to be able to produce health beyond the individual, care and medical context [1].

The FHS proposes a new dynamic for the structuring of health services, as well as for the relationship with the community, involving the different levels of care. It assumes the commitment to provide comprehensive assistance to the population, in the health unit and at home, according to their needs, identifying risk factors to which the population is exposed. In this way, it allows the FHT to intervene in an appropriate way through the humanization of health actions, seeking the satisfaction of users through a close relationship of professionals with the community and always considering health as a right of citizenship [13].

In parallel, the NASF proposes to establish another model that aims to overcome the fragmented logic of health through the construction of articulated networks of attention and care, functioning under the directives of interdisciplinary and intersectorial action. The matrix support must act in a co-responsible manner, reorienting and reorganizing the management and attention model with the ESF team.

It is worth remembering that the ESF is a Brazilian Primary Health Care (PHC) program implemented in 1994 and is characterized as a priority entry point of a health system constituted in the right to health and equal care [11].

With regard to health care focused on the NASF's performance, its guidelines need to be taken into account in order to promote health with quality and humanization of care. For this, the NASF must organize itself in strategic areas, such as: physical activity or corporal practices; Integrative and complementary practices; rehabilitation; pharmaceutical care; Food and nutrition; social service; mental health; Women's health; Health of children, adolescents and the [1].

The NASF presents, in standards, the dimensions of technical and pedagogical support. However, direct intervention of the NASF in front of users and families can only be carried out under the direction of the FHT with discussions and negotiation, a priori, among the professionals responsible for the case [14]. In fact, the direct and individualized support for the Matrix Support will occur only in situations that are extremely necessary [11].

The organization of the work processes of the NASF and the ESF should create spaces for discussion aimed at the management and establishment of a network of care. Meetings and consultations need to be a process of collective learning, with a view to producing health and enhancing the autonomy of people. In addition, when performing the diagnostic evaluation, it is necessary to consider not only the clinical knowledge but also the subjective context of the individual; it is also fundamental to define the therapeutic intervention, considering the biopsychosocial complexity of the health demands that are being referenced [15].

NASF performance

Because it is an innovative strategy, NASF implementation implies the need for the team to create routine physical spaces with support dimensions for

holding meetings, planning and discussion of cases, aiming to define therapeutic projects to be shared by all the team in a validated way and recognized by managers, in the form of PTS and PST [2].

The insertion of the NASF should modify the interaction of those involved in the process, being of fundamental relevance a new planning and the exercise of permanent education that allows its implementation, adapting the know-how to the new perspective implemented. NASF presents potentialities and weaknesses, and adjustments are necessary to make service delivery more effective and efficient [3].

The effectiveness and quality of primary health care and care should be transparent and can be achieved through a partnership between the NASF and the ESF. This does not happen in a spontaneous and natural way, and it is necessary for the professionals to assume their responsibilities under co-management between the teams and under the coordination of the local manager, in processes of constant construction.

Faced with the responsibilities entrusted to them, the NASF teams are committed to the population and to the FHT by proposing to identify community health needs while strengthening the reference teams. Its performance should be evaluated not only by result indicators for the population, but also by indicators of the outcome of its action in the team [11].

With regard to the work process of the professionals, it is expected that this will be established and agreed between the manager, NASF and ESF team; The strategies must be defined and detailed carefully, because NASF is an industry shared by personal and professional peculiarities. It is also undeniable the need to dismantle old concepts and to institute new conceptions and collective values.

Notwithstanding the advances and achievements of the FHS, NASF represents an important milestone in expanding the possibilities for achieving better health outcomes, with a focus on health promotion

and care for the population, mainly due to the support and support it offers to the ESF. The inclusion of new health professionals increases the possibility of responding to the new and old challenges of Brazilian morbidity, such as psychic suffering, changes in the nutritional pattern and increased longevity of the population, which, for the Brazilian health system. Brazil, represents a greater number of people with morbidities and, mainly, with chronic non-degenerative diseases.

In addition, this strategy offers possibilities to increase the supply of integrative and complementary practices, besides offering the best technology available for part of chronic diseases; nevertheless, it allows a reflection on treatments based only on the medicalization of patients [16].

NASF and perspectives for the decision-making front of challenges

Given the methodological proposal of the NASF regarding the development of work in an interdisciplinary way, it is necessary to have a critical review of the educational and training processes that are being made available by Higher Education Institutions in the training of health professionals.

Thus, the competences present themselves with a new perspective in the formation, although several professionals are faced with challenges when working in an inter and transdisciplinary way. In order to meet these requirements, it is necessary to reflect on the training and proficiency profile desired in this area, focusing not only on specialized technical knowledge but also on the skills and attitudes to be developed for the health of the population, in a socially responsible way [2].

Several challenges are imposed, especially when evaluating the training of health professionals who work in this strategy, such as the need to change the organization of services. In health practices, NASF professionals present difficulties in creating possibilities for joint, integrated and intersectoral action that incorporates the participation of

users in the current broader conception of health that is being assumed by SUS; there are difficulties in learning, on a daily basis, with assistance and collective work in the territory involved, which depends on flexibility and interlocution of those involved [1].

Among the difficulties that are being identified in the work process of the NASF, we highlight the training of professionals, which, in part, does not meet the needs of SUS and even less Basic Care. The transformation of training and practices is a challenge to be overcome, since it implies a change of already structured paradigms in services, in educational institutions and in interpersonal relations. With the dialogue and the approximation, in the scope of the current practices and conceptions of health care, it will be possible to reduce the mismatch between formation and reality of the services. Thus, it will favor the construction of a new form of work in health centered on the user, with quality, resolubility and equity [2].

Despite the achievements and advances in the health area, the implementation of the NASF proposes to rethink the training and the practices in health experienced so far by the FHS. The NASF brings as tools for the development of its work the extended clinic, the matriciamento, the unique therapeutic project and the health project with focus in the territory; All in order to carry out the care to the user, besides the qualification of the actions of the teams [2].

Because it is a process under construction, the implementation of the NASF suggests the need to effectively establish a professional qualification, which will only be achieved through reflection and dialogue, around a perspective that must occur both in the internal sphere of each profession As in the field of health as a whole. With this professional profile, it is possible to establish strategies such as collectively designed planning, reconstructing the meaning and meaning of its action. It is necessary that they be inserted in their practice through the

definition of therapeutic projects shared by all the team, in a validated way, allowing actions that are significantly recognized from the point of view of the managers [9].

The work of health professionals in the NASF faces several confrontations, among them the way in which the organizations have been structuring, since they conspire against the interdisciplinary and interlocution mode. And in order to overcome these challenges, in addition to working with the multi-professional team and in an interdisciplinary way, the system needs co-management so that the obstacles are known, analyzed and, where possible, removed or weakened [17].

The NASF, since its implementation, emanates challenges, especially regarding the difficulty of contemplating the integrality of individual and collective health, as proposed by MS. Therefore, it presents limitations in the scope of its services [18].

The MS proposes that the implementation of the NASF and its work strategy occur in an interdisciplinary way, in which different knowledge, knowledge, practices, values and modes of relationship are found to reach a common goal [19, 20]. Professionals are required attitudes of permeability to different knowledge and flexibility in the face of diverse needs, aspects that constitute a challenge to the practice, but which can be overcome with experimentation, that is, with the experience during the action of supporting the Involved [6].

Several health professionals overvalue autonomy, considering it the right to deliberate on cases in an isolated and definitive way. On the other hand, the matrix support promotes meetings between different perspectives, forcing professionals to compose therapeutic projects with other rationalities and worldviews. However, in cases of impasse, especially those of a therapeutic nature, there are no superior instances to solve the problem, and it is necessary for the health manager to have at least a small capacity to interfere in the specific conduct of the specialist. It is up to those involved in the

conflict to find strategies that neither harm the user nor interfere with the therapeutic design of the patient [17].

Conclusion

In order to strengthen the NASF and expand its actions more and more, diverse practices are being stimulated, individual, collective and, mainly, multidisciplinary, within the scope of the several areas of collective health in the Basic Health Care.

Some routines need to be modified, and as a consequence, discomforts will be inevitable, with direct consequences for the defense and strengthening of the NASF. Among the measures necessary for change are: reflection on the daily life with the actors involved, investment in strengthening links and creating a space for collective debate between the disciplines involved in the work process and in the Care production.

It is therefore essential to consider, with managers and organizations involved in social participation, the relationship between the composition of the teams and the health needs of the communities. It is important to recognize that health quality depends not only on a form or model, but also on the field of competencies necessary for the professional exercise.

References

1. Almeida Belas, Izaías et al. Articulated Actions of the Family Health Strategy Teams and their Centres of Support in the State of Piauí, Brazil. *International Archives of Medicine*, [S.l.], v. 10, jan. 2017. ISSN 1755-7682. Available at: <http://imedicalsociety.org/ojs/index.php/iam/article/view/2275>. Date accessed: 15 mar. 2017. doi: <http://dx.doi.org/10.3823/2275>.
2. Lima Batista Maia, Verônica Lourdes et al. Training of Professionals from the Family Health Strategy for Psychosocial Care for the Elderly. *International Archives of Medicine*, [S.l.], v. 10, jan. 2017. ISSN 1755-7682. Available at: <http://imedicalsociety.org/ojs/index.php/iam/article/view/2265>. Date accessed: 15 mar. 2017. doi: <http://dx.doi.org/10.3823/2277>.

3. Andrade LMB et al. Análise da implantação dos Núcleos de Apoio à Saúde da Família no interior de Santa Catarina. *Saúde e Transformação Social*, 2012, v.1, n.1, p.18-31.
4. Brasil. Ministério da Saúde (MS). *Portaria nº 154, de 24 de janeiro de 2008*. Cria os Núcleos de Apoio à Saúde da Família – NASF. Diário Oficial da República Federativa do Brasil. 2008. Brasília-DF, 25 jan. Available from: http://bvsms.saude.gov.br/bvs/saudelegis/gm/2008/prt0154_24_01_2008.html.
5. Brasil. Ministério do Estado da Saúde (MES). Gabinete do Ministro. *Portaria nº 2.843, de 20 de setembro de 2010*. Legislações. Gabinete do Ministro. 2010a. Available from: <http://www.brasilsus.com.br/legislacoes/gm/105513-2843.html>.
6. Brasil. *Oficina de qualificação do NASF*. Secretaria de Atenção à Saúde. Departamento de Atenção Básica. 2010c. Available from: http://bvsms.saude.gov.br/bvs/publicacoes/oficina_qualificacao_nasf.pdf.
7. Brasil. Ministério da Saúde (MS). Gabinete do Ministro. *Portaria MS/GM nº 2.488, de 21 de outubro de 2011a*. Brasília: *Diário Oficial da União*, Poder Executivo, Brasília, DF, Seção 1, p.48-55, 24 out. 2011. Available from: <http://www.corengo.org.br/attachments/article/374/PORTARIA%20MS%20N%C2%BA%202.488,%20DE%2021%20DE%20OUTUBRO%20DE%202011.pdf>.
8. Martines WRV, Chaves EC. Vulnerabilidade e sofrimento no trabalho do Agente Comunitário de Saúde no Programa Saúde da Família. *Revista da Escola de Enfermagem da USP*, 2007, v.41, n.3, p.426-433.
9. Barbosa EG et al. *Experiência da Fisioterapia no Núcleo de Apoio à Saúde da Família em Governador Valadares - MG*. *Revista Fisioterapia e Movimento*. 2012. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S010351502010000200015&lng=en.
10. Figueiredo EN. *A Estratégia Saúde da Família na Atenção Básica do SUS*. UNIFESP. UMA-SUS. 2012. Available from: http://www.unasus.unifesp.br/biblioteca_virtual/esf/2/unidades_conteudos/unidade05/unidade05.pdf.
11. Brasil. Casa Civil. Subchefia para Assuntos Jurídicos. *Decreto nº 7.508, de 28 de junho de 2011*. 2011c. Available from: http://www.planalto.gov.br/ccivil_03/_ato2011-2014/2011/decreto/D7508.htm.
12. Brasil. Ministério da Saúde (MS). Departamento de Atenção Básica. Secretaria de Atenção à Saúde. *Saúde mais perto de você: a renovação na saúde*. Revista Brasileira Saúde da Família, Ministério da Saúde, Ano XII, nº 30. Brasília, DF: Ministério da Saúde, 2011b. Available from: http://189.28.128.100/dab/docs/publicacoes/revistas/revista_saude_familia30.pdf.
13. Araújo MFS. *O enfermeiro no Programa de Saúde da Família: prática profissional e construção da identidade*. Conceitos. 2012. Available from: <http://www.saude.ms.gov.br/control/ShowFile.php?id=53553>.
14. Campos GWS, Domitti AC et al. *Apoio matricial e equipe de referência: uma metodologia para gestão do trabalho interdisciplinar em saúde*. Cadernos de Saúde Pública. 2007. Available from: http://www.scielo.org/scielo.php?script=sci_arttext&pid=S0102311X2007000200016&lang=pt&lng.
15. Brasil. Ministério da Saúde (MS). Secretaria de Atenção à Saúde. Política Nacional de Humanização. Atenção Básica. *Caderno Humaniza SUS*. 2010b. Available from: http://bvsms.saude.gov.br/bvs/publicacoes/cadernos_humanizasis_atencao_basica.pdf.
16. Mendonça CS. *Saúde da Família, agora mais do que nunca*. Ciências e Saúde Coletiva, 2009. Available from: http://www.scielo.org/scielo.php?pid=S141381232009000800022&script=sci_arttext.
17. Campos GS. *Apoio matricial e equipe de referência: uma metodologia para gestão do trabalho interdisciplinar em saúde*. Cadernos de Saúde Pública. 2007. Available from: <http://www.scielo.org/pdf/csp/v23n2/16.pdf>.
18. Vosgerau MZS et al. Consumption of medicines by adults within an area covered by a family health unit. *Ciência & Saúde Coletiva*, 2011. 16(Supl. 1):1629-1638. Available from: http://www.uff.br/higienesocial/images/stories/Consumo_de_medicamentos_entre_adultos_na_rea_de_abrangncia_de_uma_Unidade_de_Sade_da_Familia.pdf.
19. Silva AG et al. Pharmacist role in the Family Health Support Centers: a contribution to the strengthening of the Family Health Strategy. *Rev. APS*. 2016 jan/mar; 19(1): 14 – 23. Available from: <https://aps.ufjf.emnuvens.com.br/aps/article/view/2578/932>.
20. Lima ACS, Ilka VF. A formação do terapeuta ocupacional e seu papel no NASF (PE). *Cadernos de Terapia Ocupacional da UFSCar*. 2014, Vol. 22 Issue 1, p3-14. 12p.

Publish in International Archives of Medicine

International Archives of Medicine is an open access journal publishing articles encompassing all aspects of medical science and clinical practice. IAM is considered a megajournal with independent sections on all areas of medicine. IAM is a really international journal with authors and board members from all around the world. The journal is widely indexed and classified Q2 in category Medicine.